CMS-1500 & UB-04

IHCP 2019
Annual Seminar

CareSource®

Agenda

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CareSource Claims

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- Inpatient Hospital Pre-payment claim reviews
- Retrospective Authorizations for Advanced Life Support (ALS)

CareSource Health Partner Contacts

About CareSource

OUR MISSION:

To make a **lasting difference** in our members' lives by **transforming** their health and well-being

OUR PLEDGE:

- ✓ Make it easier for you to work with us
- ✓ Partner with providers to help members make healthy choices
- ✓ Direct communication
- ✓ Timely and low-hassle medical reviews
- ✓ Accurate and efficient claims payment

Submitting Institutional and Professional Claims

CareSource™

CareSource Claims

Billing Methods

CareSource accepts claims in a variety of formats:

- Electronic claims submitted through a clearinghouse
- Claim data submitted directly via our provider portal
- Postal mail

We encourage health partners to ***submit claims electronically*** for faster processing, reduced administrative costs, decreased probability of error and faster feedback on claims status.

CareSource Claims

Timely Filing

- For in-network providers, claims must be submitted within ***90 calendar days*** of the date of service or discharge.
- For out-of-network providers, claims must be submitted ***within 180 calendar days*** of the date of service or discharge.

We will not be able to pay a claim if there is incomplete, incorrect or unclear information on the claim.

Exceptions*:*

- ***Coordination of Benefits (COB):*** The claim and primary payer's explanation of payment (EOP) must be submitted to us within ***90 calendar days*** from the primary payer's EOP date. If a copy of the claim and EOP is not submitted within the required time frame, the claim will be denied for timely filing.

CareSource Claims

NPI, Tax ID and Taxonomy

The National Provider Identifier (NPI) number, Tax Identification Number (TIN) and Taxonomy Code are ***required on all claims***.

- UB-04 Claim – billing provider service location name, address and expanded ZIP Code + 4 in form field 1
- UB-04 Claim – 10 digit NPI for the billing provider in form field 56
- 1500 Claim – billing provider taxonomy code is required in 33b
- 1500 Claim – billing provider NPI is required in 33a

Please contact your Electronic Data Interchange (EDI) vendor to find out where to use the appropriate identifying numbers on the forms you are submitting to the vendor.

Rendering Provider Linkage

Health partners must be linked to all rendering locations in CoreMMIS. If not, claims will reject.

CareSource Claims

Box 33 of CMS-1500 Claim & form field 1 of the UB-04 **must** have the provider service location name, address and the ZIP code + 4 as listed on the IHCP provider enrollment profile.

PO Boxes ***will not*** be accepted in box 33. Please refer to: http://provider.indianamedicaid.com/ihcp/Banners/BR201820.pdf

Electronic Claims Submission

To submit claims electronically, health partners must work with an electronic claims clearinghouse. We currently accept electronic claims through the clearinghouses listed below.

Please provide the clearinghouse with the CareSource payer ID number **INCS1**

CLEARINGHOUSE	PHONE	WEBSITE
Availity (RealMed)	1-800-282-4548	www.availity.com
Change Healthcare (formerly Emdeon)	1-800-845-6592	www.chargehealthcare.com
Quadax	1-440-777-6305	www.quadax.com
Relay Health (McKesson)	1-866-735-2963	connectcenter.relayhealth.com

Billing Provider NPI – CMS 1500

On 837P professional claims, the billing provider NPI should be in the following location:

2010AA Loop – Billing Provider Name

- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Billing Provider NPI

2310B Loop – Rendering Provider Name

- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Rendering Provider NPI

The billing provider Tax Identification Number (TIN) must be submitted as the secondary provider identifier using a REF segment which is either the EIN for the organization or the SSN for individuals:

- Reference Identification Qualifier – REF01 = E1 (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN

On all electronic claims, the Member ID number should go on:

- 2010BA Loop – Subscriber Name
- NM109 = Member ID Name

Billing Provider NPI – UB04

On 837I Institutional claims, the billing provider NPI should be in the following location:

2010AA Loop – Billing Provider Name

- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Billing Provider NPI

2310B Loop – Rendering Provider Name

- Identification Code Qualifier – NM108 = XX
- Identification Code – NM109 = Rendering Provider NPI

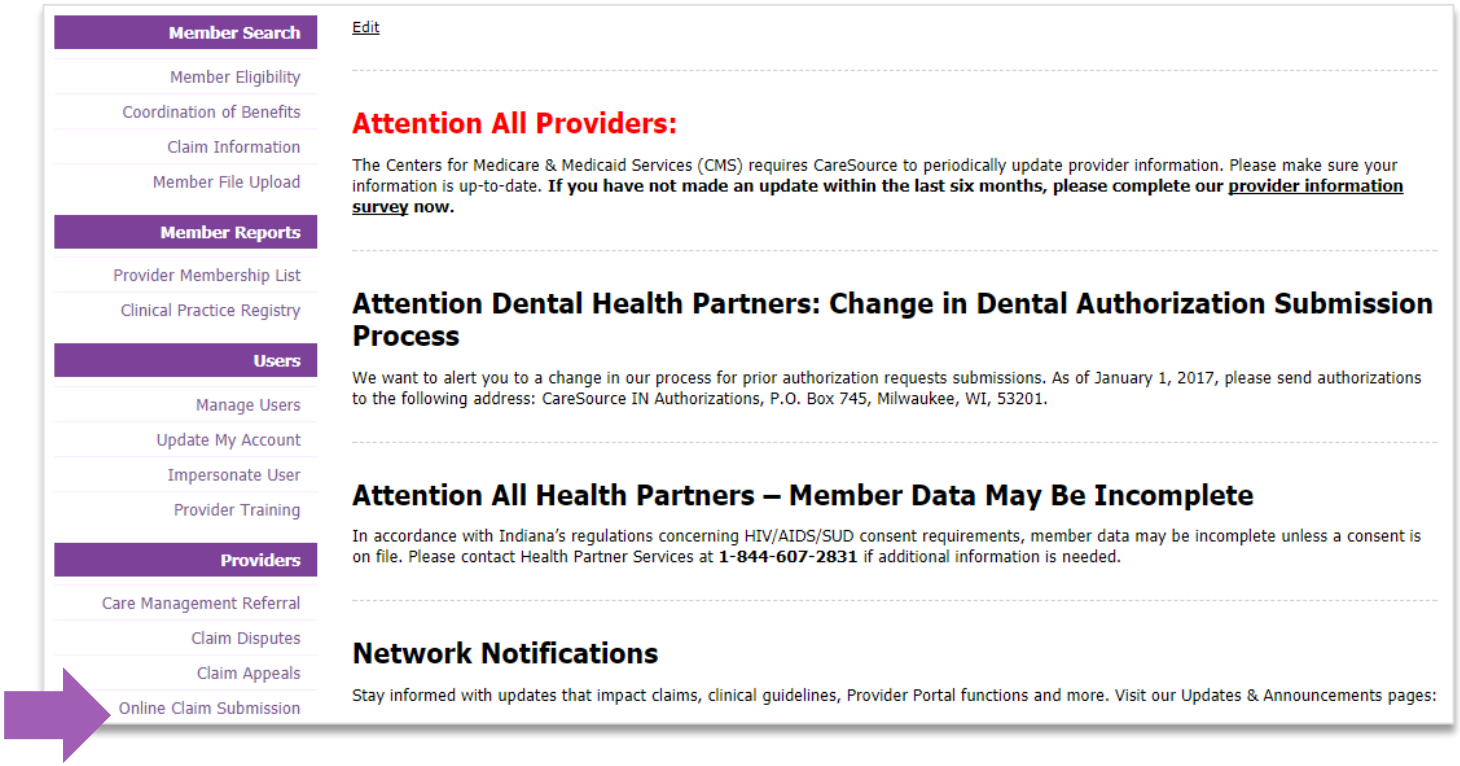
The billing health partner TIN must be submitted as the secondary provider identifier using a REF segment which is either the EIN for the organization or the SSN for individuals:

- Reference Identification Qualifier – REF01 = E1 (for EIN) or SY (for SSN)
- Reference Identification – REF02 = Billing Provider TIN or SSN

On all electronic claims, the Member ID number should go on:

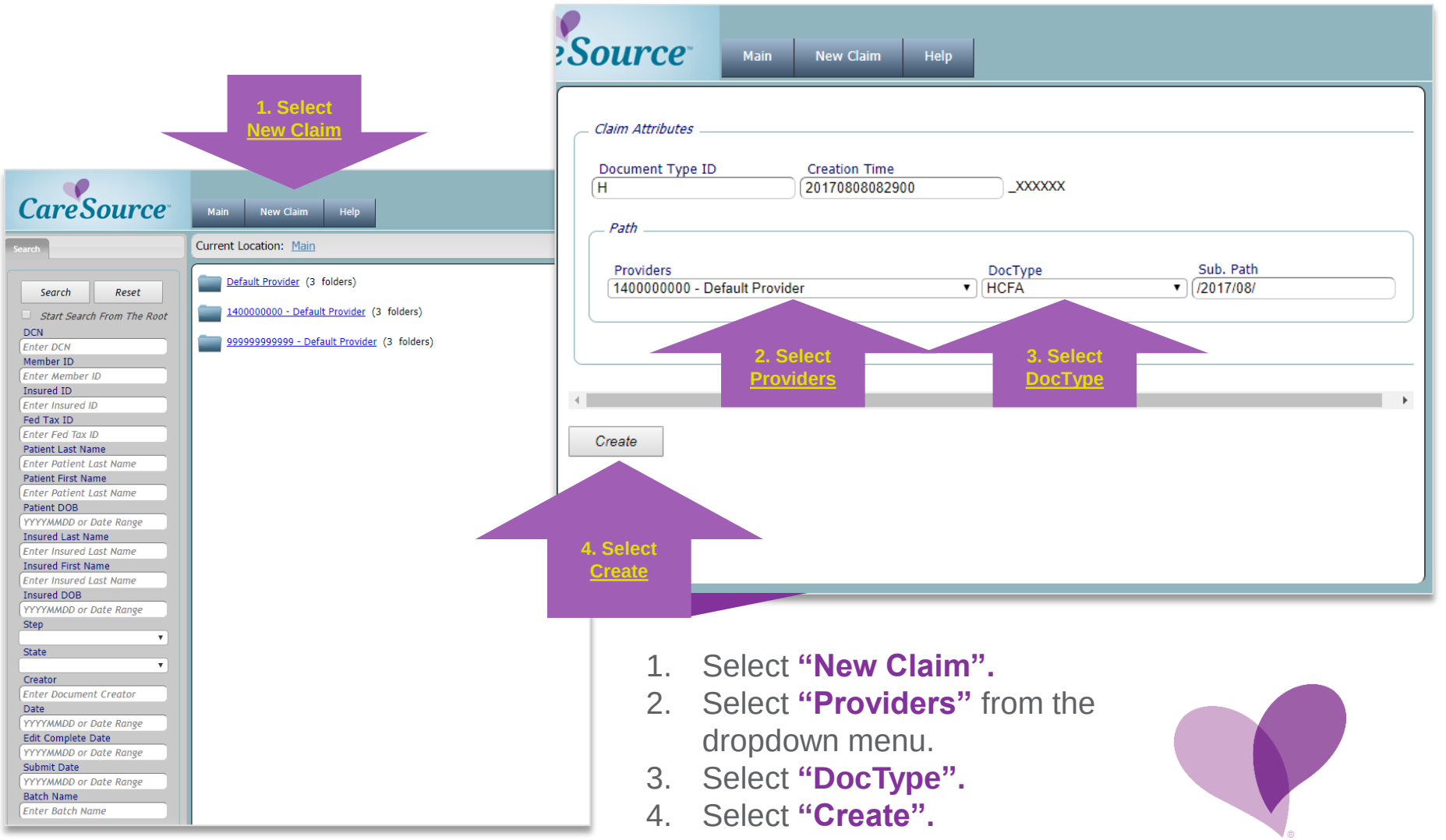
- 2010BA Loop – Subscriber Name
- NM109 = Member ID Name

Online Claim Submission



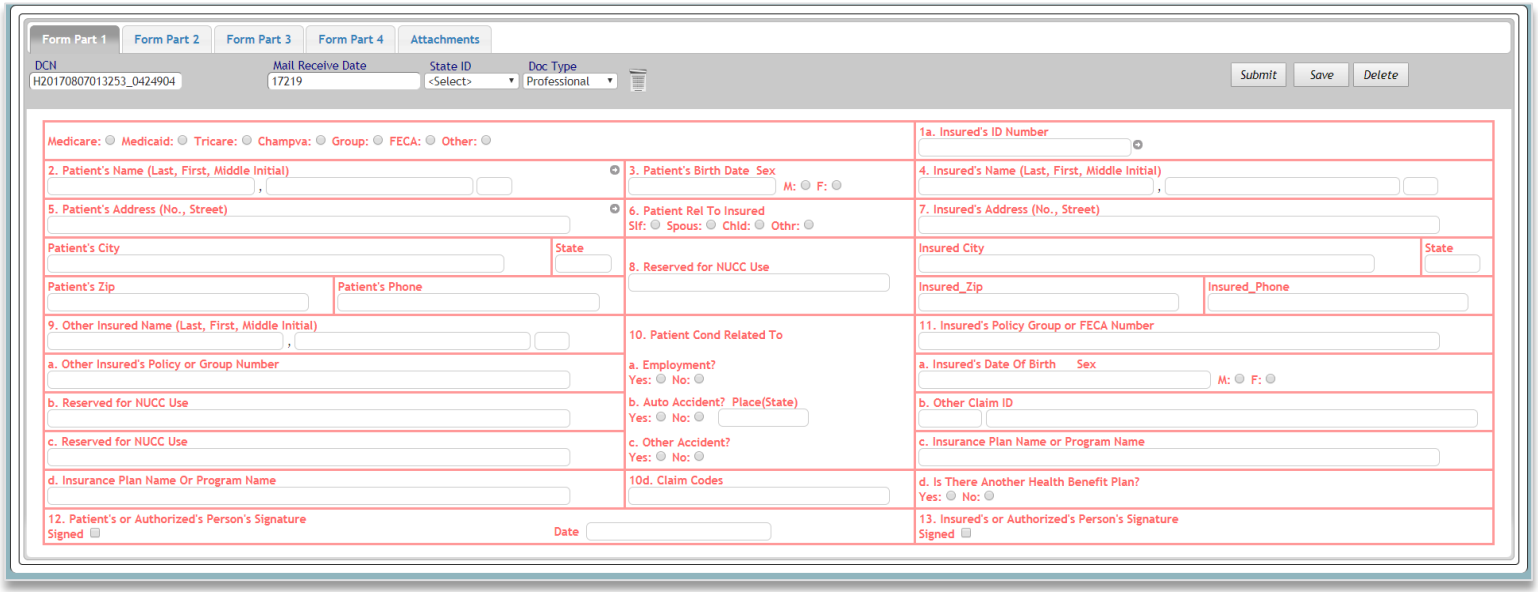
Under Providers, click on "**Online Claim Submission**".

Online Claim Submission



1. Select **“New Claim”.**
2. Select **“Providers”** from the dropdown menu.
3. Select **“DocType”.**
4. Select **“Create”.**

Online Claim Submission



Continue to complete each form and finish by clicking "**Submit**".

Paper Claim Submission

UB 04 or CMS 1500 Paper Claims

- Submission must be done using the most current form version as designated by CMS.

  CareSource does not accept handwritten claims, black and white claim forms or SuperBills.

- Detailed instructions for completing the UB 04 are available at http://provider.indianamedicaid.com/general-provider-services/provider-reference-materials.aspx

  Please note: On paper UB 04 claims, the billing providers NPI number should be placed in Box 56.

- Detailed instructions for completing the CMS 1500 are available at http://provider.indianamedicaid.com/media/155451/claim%20submission%20and%20processing.pdf

  Please note: On paper 1500 claims, the rendering NPI number should be placed in Box 24J and the billing provider NPI number in Box 33a and Group Taxonomy in 33b.

Paper Claim Submission

To ensure optimal claims processing timelines:

- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Font should be 10-14 point with printing in ***black ink.***
- Do not use liquid correction fluid, highlighters, stickers, labels or rubber stamps.
- Ensure printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- NPI, TIN and taxonomy are required for all claim submissions.

Send all paper claim forms to CareSource at:

CareSource

Attn: Claims Department

P.O. Box 3607

Dayton, OH 45401

Provider Payment Processing

CareSource™

Provider Payment Processing

Payment methods offered by ECHO Health, Inc.:

- Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA)
- Virtual Card Payment
- Paper Check

Provider Payment Processing

Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA)

(Preferred method of payment for CareSource)

To register, please visit
http://view.echohealthinc.com/eftera/EFTERAInvitation.aspx?tp=MDAxODk=

You will need:

- Your CareSource Provider ID (available via the Provider Portal or by calling Provider Services at (1-844-607-2831)
- Your bank routing number and bank account number

If already registered with ECHO, please have the following available to expedite registration:

- ECHO provider portal credentials or Tax Idenitification Number (TIN)
- An ECHO draft number and draft amount (you may use **any** ECHO draft number and corresponding draft amount issued to you by ECHO) to authenticate your registration

*When signing up without a previous payment from ECHO, select “Enroll using Enrollment Code.” Enter your CareSource Provider ID as your Enrollment Code.

Provider Payment Processing

Virtual Card Payment

Standard credit card processing & transaction fees apply. Fees are based on your credit card processor's fees and your current banking rates. ECHO does not charge any additional fee for processing.

- For each payment transaction, a credit card number unique to that payment transaction is sent either by secure fax, or by mail.
- Processing these payments is similar to accepting and entering patient payments via credit card into your payment system.

Provider Payment Processing

Paper Check Payment

If your office would prefer to receive check payments, please call ECHO Support at 1-888-485-6233.

*******Please note, for the security of your personal information, **CareSource cannot convert your banking information from InstaMed to ECHO.** If you do not proactively register with ECHO for EFT payments from CareSource, your payment method will default to QuicRemit Virtual Card Payment (VCP) or paper check.

How to Resolve a Claim Concern

CareSource™

Claim Concerns

Claim Status

Claim status is updated daily on the CareSource Provider Portal. You can check claims that were submitted for the previous 24 months.

Additional information on the portal:

- Determine reason for payment or denial
- Check numbers and dates
- Procedure/diagnosis
- Claim payment date
- View and print remittance advice
- Check status of claim disputes or appeals

Claim Concerns

Corrected Claims

- In alignment with Indiana Health Coverage Programs claim adjustment policy, providers have **60 calendar days** from the date of the explanation of payment (EOP) to submit a corrected claim for a paid claim, even if the claim paid $0, or **60 calendar days** from the date of receipt of the claim decision notification to file a claim dispute. A denied claim that is resubmitted with corrected information is considered to be an initial claim and, as such, is subject to the 90-day timely filing limit. If a claim is submitted with incorrect or unclear information, health partners have **60 calendar days** from the date of service or discharge to submit a corrected claim.
- **UB 04** claims, the health partner must include the original CareSource claim number in Box 64 and a valid type of bill frequency code in Box 4 per industry standards.
- **CMS 1500** claims, the health partner must include the original CareSource claim number and a frequency code of “7” per industry standards. When submitting a corrected or voided claim, enter a ”7” in the left-hand side of Box 22 and the original claim number in the right-hand side of that box.

Please note: If a corrected claim is submitted without this information, the claim will be processed as an original claim or rejected/denied as a duplicate.

Claim Concerns

Claim Dispute

Definition: A providers first response disagreeing with the adjudication of a claim.

- Available for participating and non-participating providers

All disputes must be:

- Submitted in writing via the CareSource Provider Portal or on paper
- Submitted within 60 days after receipt of the EOP
- Completed **prior** to requesting an appeal

If CareSource fails to render a determination for the dispute within **30 days** after receipt, an appeal may be submitted.

Claim Concerns

Claim Appeals

CareSource.com/documents/in-med-provider-clinicalclaim-appeal-form/

- May only submit appeal ***after*** completing dispute process
- Must be submitted within **60 days** of the resolution of the dispute determination OR if dispute was not responded to timely, appeal must be filed w/in **60 days** after the **30 day** dispute response window.
- CareSource must issue a written decision **45 days** of receipt of the written request for appeal
- If CareSource does not resolve appeal within the **45 day** timeframe, the appeal will be determined to be in favor of the provider
- May submit via the CareSource Provider Portal, fax (937-531-2398), or by paper to:

  Claim Appeals Department
  P.O. Box 2008
  Dayton, OH 45401-2008

- Timely filing appeals must include proof of original receipt of the appeal by fax or EDI for reconsideration

Updates/Reminders

CareSource™

Newborn Claims

- Must be submitted with the newborn's RID.
- Must include the birth weight.
- Prior Authorization is required for non participating providers.

Prior/Retro Authorization

For Ancillary Providers

In order for ancillary services requiring prior authorization to be approved, the services must be either authorized (specifically approving the ancillary services) or the primary service must be authorized. Typically an inpatient or outpatient facility will obtain prior authorization for services. However, in the event the facility does not obtain authorization, the providers group or entity delivering the care must obtain authorization. If the facility obtains an authorization, a second authorization for the group or entity is not needed.

Ancillary provider types:

- Radiology
- Anesthesiology
- Pathology
- Hospitalist services
- Labs
- Other professional services performed in an inpatient or outpatient setting

Member Billing

Not permitted:

- Balance billing a member for a Medicaid-covered service
- Billing a member in emergent situations

To charge a member for non-covered services, health partners must disclose in writing:

- Service to be rendered is not covered by Medicaid.
- Whether procedures or treatments that **are** covered by Medicaid are available in lieu of non-covered service.
- The health partner must offer, on a disclosure form, the members willingness to accept the financial responsibility of the non-covered service, the amount to be charged for the non covered service and the specific date the service is to be performed.
- ***Documentation must be signed by member prior to rendering the specific non-covered service***.

Note: Medicaid covered services **cannot** be billed to the member.

Updates & Announcements

Visit the Updates and Announcements page located on our website, https://www.caresource.com/in/providers/tools-resources/updates-announcements/medicaid/, for frequent network notifications.

Updates may include:

- Medical, pharmacy and reimbursement policies
- Authorization requirements

Important Updates

CareSource™

Duplicate Modifiers

Effective November 1, 2019, CareSource will reject claims prior to adjudication when the claim contains a duplicate modifier in the service line.

- Your EDI 999/997 HIPAA Acknowledgement will include a message to remove the duplicate modifier from your claim and resubmit.
- A retrospective review of claims is being conducted and claims may be adjusted if paid in error. Corrected claims may be submitted for claims included in the takeback. (timely filing guidelines will apply)

Inpatient Hospital Pre-Payment Claim Reviews

CareSource has contracted with Equian, LLC to conduct itemized bill reviews specific to Inpatient Hospital Claims with the following:

1) Total allowed amounts equal to or greater than $25,000.00
2) Diagnosis Related Group (DRG) outliers

Starting August 1, 2019, CareSource or Equian may contact you requesting itemized bills. Once the itemized bill is received and reviewed, billing adjustments will be made accordingly. A notice of claims review finding report will also be delivered to providers. This report will identify the line items and amounts adjusted. Typical adjustment categories include the following:

- Unbundling
- Billing Errors
- Hospital Acquired Condition
- Experimental Drugs & Procedures
- Implant Markups

Please contact Equian Claims Resolution team, at 1-888-895-2254, with questions.

https://www.caresource.com/documents/in-p-0721-provider-faq-caresource-review/

Retrospective Authorizations

For Advanced Life Support

Effective June 15, 2019, Advanced Life Support (ALS) ambulance trips are required to have a retrospective authorization for services.

- Authorization requests must be submitted within **72 hours** after the date of trip.
- Failure to submit a retrospective authorization for ALS services may result in a claim denial.

How to Reach Us

Provider Services	**1-844-607-2831**
Hours	Monday to Friday 8 a.m. to 8 p.m. (EST)
Member Services	1-844-607-2829
Hours	Monday to Friday 8 a.m. to 8 p.m. (EST)

CareSource

PARTNER with *Purpose*

CareSource Health Partner Engagement Representatives

Denise Edick, Manager, Health Partnerships
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Denise.Edick@caresource.com

Amy Williams, Team Lead, Health Partnerships
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Amy.Williams@caresource.com

Angelina Warren, Behavioral Health Partner Engagement Specialist (Northern Territory)
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Angelina.Warren@caresource.com

Stephanie Gates, Behavioral Health Partner Engagement Specialist (Southern Territory)
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Stephanie.gates@caresource.com

Brian Grcevich, Ancillary, Associations and Dental
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Brian.Grcevich@caresource.com

Contracting Managers – Hospitals/Large Health Systems

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Tenise.Hill@caresource.com

Mandy Bratton – South
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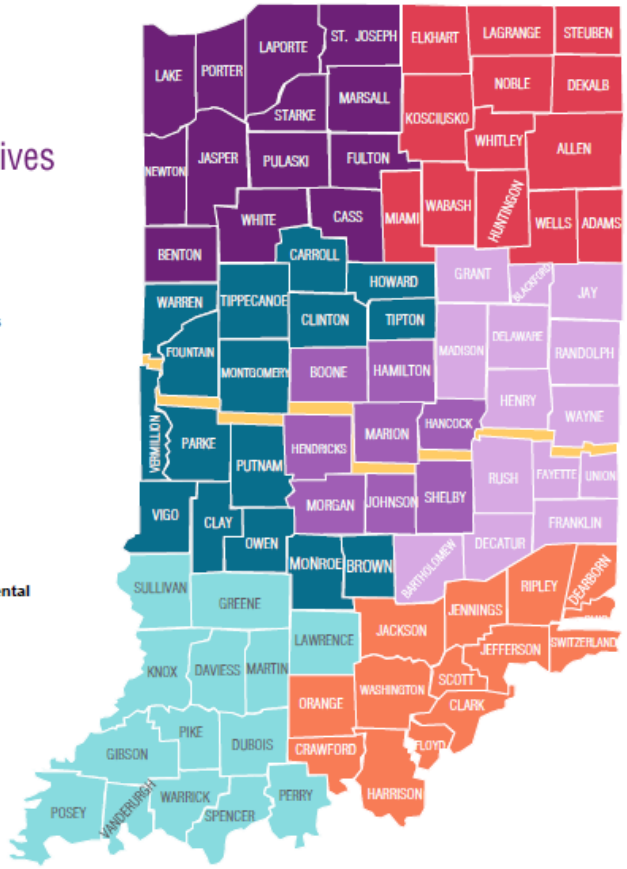
Mandy.Bratton@caresource.com



Regional Representatives

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IN-P-0799 Issue Date:

CareSource®
OMPP Approved:

Session Survey - Tuesday

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.

https://tinyurl.com/fssa1010

Session Survey - Thursday

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.

https://tinyurl.com/fssa1036